CATER CHIROPRACTIC CLINIC

CHILD'S CONFIDENTIAL HEALTH REPORT

Child's Name_____ Birth Date _____ Age _____

Phone Number_____ Address _____

City _____ Zip Code_____

Male/ Female Height_____ Weight _____ Referred By _____

Parent's Names _____

Person Responsible for Billing _____

Address (If different from above) _____

Home Phone _____ Work Phone _____

Main reason for seeking this consultation and how long has the child had the problem?

_____

_____

If any other Doctors have been seen for this condition please list the doctor's name and what treatments were given?_____

_____

Are you satisfied with the results that you have had? Yes/ No
Date of Last Chiropractic Visit _____

Name of Chiropractor _____ Diagnosis _____

Date of Last Medical Exam _____ Name of Pediatrician _____

List Any Surgeries The Child Has Had _____

List the number of antibiotics your child has taken in the last:
6 months _____, Total during lifetime _____ Date of last vaccination _____

List the number of doses and names of other medications taken in the last:
6 months _____

Total during lifetime _____

Birth Place: Home / Hospital / Birth Center **Type:** Vaginal / C-Section

Was Vacuum Extraction or Forceps Used? Yes / No

Birth: Premature / Term

How long was the labor? _____

Was the delivery different? _____

Was the mother given medicine during the delivery? _____

Was the labor induced? _____

Is / Was your child breast fed? _____ For how long? _____

Check any of the following conditions that your child has suffered from:

____ ADHD
____ Asthma/ Allergies
____ Bed Wetting
____ Bronchitis
____ Cerebral Palsy
____ Chicken Pox
____ Chronic Colds
____ Colic
____ Constipation
____ Diabetes
____ Diarrhea
____ Digestive Problems
____ Ear Infections
____ Growing or Back Pains
____ Headaches
____ Irritability
____ Jaundice at Birth
____ Pneumonia
____ Recurring Fevers
____ Scoliosis
____ Seizures
____ Sinus Infections
____ Sleeping Problems
____ Strep Throat
____ Tonsillitis
____ Crossed Eyes
____ Other

Vaccination History: (Please check and give age of child at time of vaccination)

____ HBV / Hep B (Hepatitis B); Age _____
____ MMR (Measeles, Mumps, Rubella); Age _____
____ DTP –or- ____ DTaP (Diphtheria, Tetanus, Pertussis); Age _____
____ Varicella (Chicken Pox); Age _____
____ HbCV / Hib (H. influenza type b conjugate); Age _____
____ PCV (Pneumoccocal); Age_____
____ OPV (Oral Polio Vaccine) –or- ____ IPV (Inactivated Poliovirus); Age _____

Adverse Reactions to Any Vaccine? Y / N
List: _____

Comments:
_____
_____

I certify that the information on this form is true to the best of my knowledge.

Signature of Parent/Legal Guardian Date